Make It Yours **To Go**

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Eligibility

It's important to be aware of who is eligible for coverage under your medical, dental, vision, and other benefits. Please take a moment to review the information below to ensure you have everything you need before enrolling.

Full- and part-time employees regularly scheduled to work 20 hours or more per week are eligible for the group health benefits described on this website. Interns, Temporary and As-Needed employees are not eligible to participate. Employees are eligible on the first day of the month following or coincident with their date of hire.

Except as specified on this website, the term “spouse” includes your Domestic Partner. For information on FTI Consulting's Domestic Partner Policy, email **human.resources@fticonsulting.com**.

Eligible Dependents for Medical, Dental, and Vision Coverage
Your eligible dependents include:

- A spouse to whom you are legally married;
- A Domestic Partner; as defined under FTI Consulting's Domestic Partner Policy;
- A dependent child under age 26. Coverage will terminate on the day the dependent child turns 26 years old. A dependent child is your natural-born child, legally adopted child (or child who has been placed in your home for adoption), stepchild or child for whom the court has appointed you as legal guardian; and
- A dependent child incapable of self-sustaining employment who is unmarried, age 26 or old, and dependent on you for a majority of financial support. The child must have become disabled before age 26 and must have already been your dependent at the time of disability (and continues to be your dependent). Satisfactory evidence of disability and attestation of satisfying the above requirements for a disabled dependent child may be requested from time to time from your insurance carrier.

When Does Coverage Begin?
Coverage for the benefits described on this website will begin as follows:

- First day of the month following or coincident with the date of hire, initial benefits eligibility date, or qualifying status change event date.
- January 1 of the year following the Open Enrollment period.

Benefit Changes
Benefit elections made for medical, dental, vision, life, AD&D, disability, and flexible spending accounts (health care and/or dependent care) will remain in effect and cannot be changed or revoked until an affirmative election is made during the Open Enrollment period. Outside of the Open Enrollment period, a Qualified Status Change which affects the type of coverage or coverage level needed is permitted within 31 calendar days of the qualifying event. The FTI U.S. Benefits Guide, located on **FTI *Atlas***, provides information on the Qualifying Events defined by the IRS.

Medical Coverage Level

Which Coverage Level Is Best?

When you choose your coverage level, you get to pick the one with the coverage and features you want. If you're enrolling again, consider what changes you may be facing. Change is constant, so make sure you **do your homework** before sticking with what you had in the past.

Your coverage level determines how much you pay out of your paycheck (premiums). It also determines how much you pay out of your pocket when you receive care (deductibles, coinsurance, copays).

Don't let the names of the coverage levels fool you. One option isn't better than another. The coverage levels are designed to give you choices. It's up to you to find the one that makes sense for your situation.

Medical Coverage Level Options

You have several coverage levels to choose from. Each coverage level is available from different **insurance carriers** at different costs.

When you enroll, you'll find plenty of tools and resources to help you choose a coverage level.

	BRONZE PLUS	SILVER	GOLD	PLATINUM
Option type	High-deductible option with HSA	High-deductible option with HSA	PPO	PPO
Paycheck contributions	$	$$	$$$	$$$$
		2026 Annual Deductible		
In-network (individual / family)	$2,500 / $5,000	$1,700 / $3,400	$800 / $1,600	$250 / $500
Out-of-network (individual / family)	$2,500 / $5,000	$1,700 / $3,400	$1,600 / $3,200	$5,000 / $10,000
Traditional or true family?	True family	True family	Traditional	Traditional
		2026 Annual-Out-of-Pocket-Maximum		
In-network (individual / family)	$4,500 / $9,000	$4,250 / $8,500	$3,600 / $7,200	$2,300 / $4,600
Out-of-network (individual / family)	$11,500 / $23,000	$8,500 / $17,000	$7,200 / $14,400	$11,500 / $23,000
Traditional or true family?	True family	True family	Traditional	Traditional

		2026 In-Network Benefits		
Preventive care	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible
Doctor's office visit	You pay 25% after deductible	You pay 25% after deductible	You pay $25 for PCP visit and $40 for specialist visit, no deductible	You pay $25 for PCP visit and $40 for specialist visit, no deductible
Emergency room	You pay 25% after deductible	You pay 25% after deductible	You pay $150, then 20% after deductible	You pay $150, then 15% after deductible
Urgent care	You pay 25% after deductible	You pay 25% after deductible	You pay $40	You pay $25
Inpatient care	You pay 25% after deductible	You pay 25% after deductible	You pay 20% after deductible	You pay 15% after deductible
Outpatient care	You pay 25% after deductible	You pay 25% after deductible	If not an office visit, you pay 20% after deductible	If not an office visit, you pay 15% after deductible

Note: For some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, the coverage is an HMO option that covers in-network care only.

Prescription Drug Coverage

	BRONZE PLUS	**SILVER**	**GOLD**	**PLATINUM**
Preventive drugs	You pay $0**	You pay $0**	You pay $0**	You pay $0**
		30-Day Retail Supply		
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $10	You pay $8
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $40	You pay $30
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $60	You pay $50
		90-Day Mail Order Supply		
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $25	You pay $20
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $100	You pay $75

Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $150	You pay $125

**Preventive drugs are determined by the insurance carrier or pharmacy benefit manager. You must have a doctor's prescription for the medication—even for products sold over the counter (OTC)—and you must use an in-network retail pharmacy or mail-order service.

These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here. In the event that there is a discrepancy between this site and the official plan documents, the official plan documents will control.

These charts are a high-level listing of commonly covered benefits across carriers and coverage levels. They are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits.

For a more detailed look at these and additional coverages, go to the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**. It does account for any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, you will need to call the carrier directly.

Note: For additional comparison, you may find Summaries of Benefits and Coverage on the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**.

California Residents: Your options will be different, depending on the insurance carrier you choose. See **what's different**.

Out-of-Area: Your specific options are based on your home zip code. If you live outside the service areas of all the insurance carriers, you can choose an out-of-area option at the Silver coverage level. Aetna will be the insurance carrier. (Note: The Silver option available to out-of-area individuals is different than the Silver option on this site. Refer to **yourbenefitsresources.com/fticonsulting/onelogin** for details.)

Choosing a Primary Care Physician: Certain options require you to choose a primary care physician. You may need to designate a primary care physician to coordinate your care if you choose Kaiser Permanente or Health Net as your insurance carrier.

Do You Take Any Prescription Drugs?

Your prescription drug coverage will be provided through your insurance carrier's pharmacy benefit manager.

While your coverage level will determine your coverage for prescription drugs, each pharmacy benefit manager has its own rules. You need to make sure you're comfortable with how your family's medications will be covered. **Get the details**.

Questions?

Check out the **Frequently Asked Questions** (PDF) and the **Glossary**.

California Medical Coverage Level

Live In California?

Your options will be different, depending on the insurance carrier you choose.

For starters, each **insurance carrier** in California can elect to offer each coverage level either as an option that offers in- and out-of-network benefits (e.g., a PPO) **or** an option that offers in-network benefits only (e.g., an HMO).

Also, insurance carriers can choose to offer **either the standard Gold option or a Gold II option—not both**. The Gold II option offers **only** in-network benefits.

Review the table below to see which insurance carriers offer out-of-network benefits for the coverage levels you're considering.

	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
Aetna	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In- and out-of-network
CareFirst	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In- and out-of-network
Cigna	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In-network only
Health Net	In- and out-of-network	In- and out-of-network	N/A	In-network only	In- and out-of-network
Kaiser Permanente	In-network only	In-network only	N/A	In-network only	In-network only
United Healthcare	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In- and out-of-network

Medical Coverage Level

	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM

Option type	High-deductible option with HSA	High-deductible option with HSA	PPO	HMO	PPO
Paycheck contributions	$	$$	$$$	$$$	$$$$
		2026 Annual Deductible			
In-network (individual / family)	$2,500 / $5,000†	$1,700 / $3,400†	$800 / $1,600	N / A	$250 / $500
Out-of-network (individual / family)	$2,500 / $5,000†	$1,700 / $3,400†	$1,600 / $3,200	N / A	$5,000 / $10,000
Traditional or true family?	True family	True family	Traditional	N / A	Traditional
		2026 Annual Out-of-Pocket Maximum			
In-network (individual / family)	$4,500 / $9,000†	$4,250 / $8,500†	$3,600 / $7,200	$5,400 / $10,800	$2,300 / $4,600
Out-of-network (individual / family)	$11,500 / $23,000†	$8,500 / $17,000†	$7,200 / $14,400	N / A	$11,500 / $23,000
Traditional or true family?	True family	True family	Traditional	Traditional	Traditional
		2026 In-Network Benefits			
Preventive care	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%	Covered 100%, no deductible
Doctor's office visit	You pay 25% after deductible	You pay 25% after deductible	You pay $25 for PCP visit and $40 for specialist visit, no deductible	You pay $25 for PCP visit and $40 for specialist visit	You pay $25 for PCP visit and $40 for specialist visit, no deductible

Emergency room	You pay 25% after deductible	You pay 25% after deductible	You pay $150, then 20% after deductible	You pay $150, then 30% after copay	You pay $150, then 15% after deductible
Urgent care	You pay 25% after deductible	You pay 25% after deductible	You pay $40	You pay $40	You pay $25
Inpatient care	You pay 25% after deductible	You pay 25% after deductible	You pay 20% after deductible	You pay 30%	You pay 15% after deductible
Outpatient care	You pay 25% after deductible	You pay 25% after deductible	If not an office visit, you pay 20% after deductible	If not an office visit, you pay 30%	If not an office visit, you pay 15% after deductible

Note: For some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, the coverage is an HMO option that covers in-network care only.

†Under Health Net and Kaiser Permanente, there are minor differences (including possible lower family deductibles and a **traditional** annual deductible and out-of-pocket maximum) under the Bronze Plus and Silver coverage levels.

Prescription Drug Coverage

	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
Preventive drugs	You pay $0**	You pay $0**	You pay $0**	You pay $0**	You pay $0**
			30-Day Retail Supply		
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $10	You pay $10	You pay $8
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $40	You pay $40	You pay $30
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $60	You pay $60	You pay $50
			90-Day Mail Order Supply		
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $25	You pay $25	You pay $20

Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $100	You pay $100	You pay $75
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $150	You pay $150	You pay $125

**Preventive drugs are determined by the insurance carrier or pharmacy benefit manager. You must have a doctor's prescription for the medication—even for products sold over the counter (OTC)—and you must use an in-network retail pharmacy or mail-order service.

These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here. In the event that there is a discrepancy between this site and the official plan documents, the official plan documents will control.

These charts are a high-level listing of commonly covered benefits across carriers and coverage levels. They are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits.

For a more detailed look at these and additional coverages, go to the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**. It does account for any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, you will need to call the carrier directly.

Note: For additional comparison, you may find Summaries of Benefits and Coverage on the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**.

Out-of-Area: Your specific options are based on your home zip code. If you live outside the service areas of all the insurance carriers, you can choose an out-of-area option at the Silver coverage level. Aetna will be the insurance carrier. (Note: The Silver option available to out-of-area individuals is different than the Silver option on this site. Refer to **yourbenefitsresources.com/fticonsulting/onelogin** for details.)

Choosing a Primary Care Physician: Certain options require you to choose a primary care physician. You may need to designate a primary care physician to coordinate your care if you choose Kaiser Permanente or Health Net as your insurance carrier.

Do You Take Any Prescription Drugs?

Your prescription drug coverage will be provided through your insurance carrier’s pharmacy benefit manager.

While your coverage level will determine your coverage for prescription drugs, each pharmacy benefit manager has its own rules. You need to make sure you’re comfortable with how your family's medications will be covered. **Get the details**.

Questions?

Check out the **Frequently Asked Questions** (PDF) and the **Glossary**.

How Deductibles Work

The deductible is what you pay out of your own pocket before your insurance begins to pay a share of your costs.

For example, let's say you break your wrist. If you have a deductible, you pay the full "negotiated" costs of all in-network services until you reach the deductible. The "negotiated" costs are the payments providers (doctors, hospitals, labs, etc.) have agreed to accept for a particular service from the **insurance carrier**. Insurance carrier member sites and apps have resources that can help you look up the cost of care.

It Depends On Your Medical Coverage Level

Gold and Platinum have a traditional deductible. Once a covered family member meets the individual deductible, your insurance will begin paying benefits for only that family member.

Charges for all other covered family members will continue to count toward the family deductible. Once the family deductible is met, your insurance will pay benefits for all covered family members.

The annual deductible doesn't include amounts taken out of your paycheck for health coverage.

Bronze Plus and Silver have a "true family deductible". This means that the entire family deductible must be met before your insurance will pay benefits for any covered family members.

There is no "individual deductible" in the Bronze Plus and Silver coverage levels when you have family coverage. So even if only one person in your family has a lot of expenses, the full family deductible must be met before insurance will begin to pay its portion of benefits.

The annual deductible doesn't include amounts taken out of your paycheck for health coverage. Also, copays for certain medical benefits may not apply towards the annual deductible.

Do You Use Out-of-Network Providers?

Out-of-network charges will **not** count toward your in-network deductible or out-of-pocket maximum. The same goes for in-network charges—they will **not** count toward your out-of-network deductible or out-of-pocket maximum.

Some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, do **not** cover out-of-network benefits at all.

How Out-of-Pocket Maximums Work

The out-of-pocket maximum is the most you have to pay for covered medical services in a year. Generally, it includes any applicable deductible, copayments, and/or coinsurance.

It Depends On Your Medical Coverage Level

Gold and Platinum have a traditional out-of-pocket-maximum. Once a covered family member meets the individual out-of-pocket maximum, your insurance will pay the full cost of covered charges for that family member.

Charges for all covered family members will continue to count toward the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, your insurance will pay the full cost of covered charges for all covered family members.

It doesn't include amounts taken out of your paycheck for health coverage.

Bronze Plus and Silver have a "true family out-of-pocket-maximum". This means that the entire family out-of-pocket maximum must be met before your insurance will pay the full cost of covered charges for any covered family member.

There is no "individual out-of-pocket maximum" in the Bronze Plus and Silver coverage levels when you have family coverage.

The annual out-of-pocket maximum doesn't include amounts taken out of your paycheck for health coverage.

Do You Use Out-of-Network Providers?
Out-of-network charges will **not** count toward your in-network deductible or out-of-pocket maximum. The same goes for in-network charges—they will **not** count toward your out-of-network deductible or out-of-pocket maximum.

Some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, do not cover out-of-network benefits at all.

Medical Price

How much you pay out of your paycheck is one thing. You also have to consider what you'll pay throughout the year when you need care.

How much you'll pay for medical coverage depends on:

The Amount Of Your Contribution From FTI Consulting

All eligible employees will receive a contribution to use toward the cost of coverage.

You'll see the contribution amount from FTI Consulting and your price options for coverage when you **enroll**.

The Coverage Level You Choose

The Bronze Plus and Silver coverage levels cost less per paycheck, but you will pay a higher deductible before your coverage kicks in.

The Gold and Platinum coverage levels cost more per paycheck, but you'll probably pay less out of pocket for services throughout the year.

Learn more about coverage levels.

The Insurance Carrier You Choose

Since each coverage level is covered the same across carriers, it's easy to see which insurance carrier offers the lowest cost for the same coverage. For example, if you know you want a Silver option, you can look to see how much each insurance carrier would charge you for it. **Learn more about insurance carriers.**

Important: Choose an insurance carrier whose network includes providers critical to your care. If you see an out-of-network provider, your medical insurance carrier could pay a much lower benefit —leaving you to pay the rest.

Your Dependents

You can enroll any combination of you, your eligible spouse/domestic partner, and your children in the option you choose.

Pay Now or Later?

It's a trade-off. It's up to you to choose which option gives you the best value on your total health care costs.

Would you rather pay **less** now and **more** when you need care? Or pay **more** now and **less** when you need care?

Pay Less *Now*

The Bronze Plus and Silver coverage levels cost less per paycheck, but your deductible is higher. That means you'll pay more out of your pocket when you need care.

Make sure you know **how the deductible works**. Also, make sure the deductible amount is something you could afford in the event you need a lot of health care.

TIP: You can save money by enrolling in an **HSA** when you enroll in a Bronze Plus or Silver coverage level.

Pay Less *Later*

The Gold and Platinum coverage levels cost more per paycheck, but your deductible is lower. If you don't expect to have a lot of health care needs, you could be spending money for benefits you don't use.

How to Get the Right Medical Option

Now that you understand the basics, it's time to put it all together. There are several resources to help you get confident before you enroll—including the Help Me Choose tool, an integrated guidance tool that can help you look up providers, prescription drugs, and more.

Get ready now so when it's time to enroll, you'll have answers to the following questions.

Which Providers Are In The Carrier's Network?

Why It Matters
Seeing out-of-network providers will cost you more—sometimes a lot more. For example, you will have to pay more through a higher deductible and higher coinsurance. You'll also have to pay the entire amount of the out-of-network provider's charge that exceeds the maximum allowed amount. And certain options in some states won't cover out-of-network services at all.

What to Do
Choose an insurance carrier whose network includes providers (e.g., doctors, specialists, hospitals) critical to your care.

Do **not** rely on your provider's office to know the carriers' network(s). To search for providers:

- Check out the **insurance carrier** preview sites.
- When you enroll, check the networks of each insurance carrier you're considering on the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**. You can access this information by entering your provider information in the Help Me Choose tool or clicking **Find Doctors** when you're selecting your medical plan. For the best results:
    - Search for your provider by name—not medical practice.
    - Check only the office location(s) you are willing to visit.
    - When searching for a facility, use the complete facility name and confirm whether the specialty of the facility is covered in-network.

Important! Do **not** rely on your provider's office to know the carriers' network(s). If you have any uncertainty (for instance, covering out-of-area dependents) or you need the network name, call the insurance carrier.

Even if you can keep your current insurance carrier, the provider network could be different and can change, so always check the provider networks on the carrier preview sites before making a decision.

How Will My Prescription Drugs Be Covered?

Why It Matters
Each pharmacy benefit manager has its own rules about how prescription drugs are covered. To avoid potentially costly surprises, you need to do your homework.

What to Do
If you or a covered family member regularly takes medication, make sure you're comfortable with the insurance carrier's coverage for drugs you and your covered family members need:

- Call the medical **insurance carrier** before you enroll. Get a list of **prescription drug questions** to ask.
- If you're currently taking a more expensive brand name prescription drug, ask your doctor (or pharmacist) if a generic is available to you.
- When it's time to enroll, you can use the Help Me Choose tool to look up how your medication will be classified (Tier 1, Tier 2, Tier 3) and more.

Which Medical Coverage Level Is Best For Me?

Why It Matters
You want to get the right amount of coverage for your needs at the best price. Get help choosing the right level of coverage.

What to Do
If you need help deciding, there are tools to help you:

- Get an overview of your medical **coverage levels**.
- See which coverage level could be **best for you** with the Help Me Choose tool. By answering a few questions about your preferences when you enroll, you can see which option could be a good fit for you and your family.
- Compare your options side by side when you enroll on the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**. Just check the boxes next to medical options you want to review and click **Compare**. You can quickly see which options cost more out of your paycheck and which options cost more when you get care. (You may also find Summaries of Benefits and Coverage for comparison on the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**.)

Which Medical Insurance Carrier Is Best For Me?

Why It Matters
All insurance carriers are different. Each carrier will offer its own price and provider network, and you'll be able to see all of the prices in one place when you enroll on the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**. (**Note:** The benefits provided under a coverage level will be very similar across carriers, but there could be some differences.)

What to Do
If you need help deciding:

- Use Help Me Choose—an interactive decision-making tool that allows you to compare your options based on your preferences, doctors, and prescriptions.
- Compare the details, when you enroll online, by checking the boxes next to medical options you want to review and clicking **Compare**. That makes it easy to see which carrier is offering you the most value. (You may also find Summaries of Benefits and Coverage for comparison on the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**.)

- Browse the carrier **preview sites** to learn about programs, tools, and other considerations that could influence your decision.

Ready to enroll? **Find out how.**

HSA Basics

An HSA—or Health Savings Account—is a special bank account that you can use when you enroll in a Bronze Plus or Silver coverage level. If you also have coverage under a second medical plan, it must also be a high-deductible option for you to use an HSA.

It's a great way to save for the future. Just set aside a few dollars from each paycheck now, and then you'll have funds to help cover health care expenses that come up. Plus, it's tax-free, so you're actually getting a better deal.

You can decide if you want to enroll in an HSA when you enroll for benefits. That's a great time to **decide how much to save**.

You can change the amount you save at any time throughout the year.

Why Consider An HSA?

You'll be responsible for 100% of your medical and prescription drug expenses until you meet your deductible in the Bronze Plus or Silver coverage level. An HSA is a great way to pay less for those out-of-pocket expenses because you're using tax-free money.

Let's say you injure your knee. With a high deductible, you might worry about how you're going to afford the medical bills.

Now imagine if you had already set aside money for expenses like these. That's where an HSA comes in handy. You could already have saved the money you need.

An HSA allows you to set aside tax-free money to pay for qualified health care expenses. This includes your medical, dental, and vision copays, deductibles, and coinsurance.

It's Tax-Free—And Yours To Keep!

While no one likes taking money out of their paycheck, there are a number of advantages to setting aside a little money in an HSA.

It's tax-free when it goes in. You can put money into your HSA on a before-tax basis through convenient payroll contributions. You'll save money on qualified health care expenses and lower your taxable income.

It's tax-free as it grows. You earn tax-free interest on your money.

It's tax-free when you spend it. When you spend your HSA on qualified health care expenses, you don't pay any taxes. That means you're saving money on your qualified medical, dental, and vision expenses.

It's always your money. You can carry over your unused HSA balance from year to year. Just like a bank account, you own your HSA, so it's yours to keep and use even if you change medical options, leave the company, or retire.

Important! Make sure you use money in your HSA only for qualified health care expenses. Otherwise, you'll pay income taxes on that distribution. You'll also pay an additional 20% penalty tax if you're under age 65.

HSAs are covered by the U.S. Patriot Act which has strict guidelines in place for verifying the account holder's identity. As part of the verification process, Bank of America must verify the customer's name, physical address, date of birth and SSN. In order to ensure your account remains active, please provide the requested documentation back to Bank of America.

Questions?

Get answers to your questions, including eligibility rules, how to contribute, and more.

If you enroll in a Bronze Plus or Silver coverage level, learn how the HSA works in the **HSA User's Guide** (PDF).

HSA vs FSA

Wondering how an HSA is different from a Health Care Flexible Spending account (FSA)? Here's how:

	HEALTH SAVINGS ACCOUNT	HEALTH CARE FLEXIBLE SPENDING ACCOUNT
When to Use	You can use the HSA to pay for eligible medical, dental, and vision expenses under the Bronze Plus or Silver coverage levels.	You can use the Health Care FSA to pay for eligible medical, dental, and vision expenses under the Gold or Platinum coverage levels, or if you waive medical coverage.
Contributions	You can contribute to your account before taxes. For 2026, the annual limits set by the IRS are $4,400 for individual coverage, and $8,750 for family coverage. If you're age 55 or older (or will turn age 55 during the plan year), you can also contribute an additional $1,000 catch-up contribution.	You can contribute to your account before taxes, up to the $3,300 annual limit.
Rollovers	Unused dollars roll over from year to year. The funds are always yours to keep, even if you leave the company or retire.	You can only roll over up to $660 from year to year.
Earning Interest	The money in your HSA earns interest.	The money in your FSA does **not** earn interest.
Debit Cards	Yes, a debit card is available.	Yes, a debit card is available for the Health Care FSA.
Investment Option	You can open an investment account when your balance reaches $1,000.	You cannot invest your FSA balance.

How Much to Save?

You decide how much money you want to save in your HSA, and you can change it at any time. It's a smart idea to save enough to cover your annual deductible.

For 2026, you can save up to $4,400 if you're covering just yourself, or $8,750 if you're covering yourself and your family. If you're age 55 or older (or will turn age 55 during the plan year), you can also make additional "catch-up" contributions to your HSA up to $1,000.

And if you don't need that much health care, your money stays in your account and earns tax-free interest. It's a great way to save for future expenses.

Prescription Drugs

Your prescription drug coverage will be provided through your insurance carrier's pharmacy benefit manager.

That means your prescription drug coverage depends on the medical coverage level you choose **and** your medical **insurance carrier.**

Your Coverage Level Matters

You pay nothing for preventive drugs, as determined by your insurance carrier. You need a doctor's prescription, and you must use an in-network retail pharmacy or mail-order service.

Bronze Plus or Silver
You pay the full cost for prescription drugs until you reach the annual medical deductible. Then you pay coinsurance. Once you reach the out-of-pocket maximum, you pay nothing.

Gold or Platinum
You pay a copay for all prescription drugs. Once you reach the out-of-pocket maximum, you pay nothing.

Your specific prescription coverage is based on the medical coverage level you select. **Get the details**.

Your Carrier Matters

Each pharmacy benefit manager has its own rules about how prescription drugs are covered. So you need to do your homework to find out how your medications will be covered—**before** choosing an insurance carrier.

Get a list of **prescription drug questions** to ask.

Prescription Drug Questions

Your prescription drug coverage will be provided through your **insurance carrier's** pharmacy benefit manager. Each pharmacy benefit manager has its own rules about how prescription drugs are covered. So **you need to do your homework** to find out how your medications will be covered—**before** you choose an insurance carrier.

What To Ask

Here's a list of questions to ask each carrier you're considering.

Tip: You can also print out the **Prescription Drug Transition Worksheet** (PDF) and use it to take notes.

Is my drug on the formulary?
A formulary is a list of generic and brand name drugs that are approved by the Food and Drug Administration (FDA) and are covered under your prescription drug plan. If your drug isn't listed on the formulary, you'll pay more for it.

How much will my drug cost?
It depends on how your medication is classified—Tier 1, Tier 2, or Tier 3. Typically, the higher the tier, the more you'll pay.

While generics typically cost less than brand name drugs, higher-cost generics can be classified as Tier 2 or Tier 3 drugs. This means you'll pay the Tier 2 or Tier 3 price for certain generic drugs. You can find this information by using the prescription drug search tool when you enroll.

Will I have to pay a penalty if I choose a brand name drug?
Because many brand name drugs are so expensive, some medical insurance carriers will require you to pay the copay or coinsurance of a higher tier—**plus** the cost difference between brand and generic drugs—if you choose a brand when a generic is available.

Is my drug considered "preventive" (covered 100%)?
The Affordable Care Act requires that certain preventive care drugs are covered at 100% when you fill them in-network. You can view a list of drugs considered to be "preventive" when you enroll. If a drug isn't on the preventive drug list, you'll have to pay your portion of the cost.

Will my doctor have to provide more information before my prescription drug can be approved?
Many medications require approval before they are covered. This may apply for costly medications that have lower-cost alternatives or aren't considered medically necessary.

What is a step therapy program?
If this applies to one of your medications, you'll need to try using the most cost-effective version first—usually the generic. A more expensive version will be covered only if the first drug isn't effective in treating your condition.

Are there any quantity limits for my medication?
Certain drugs have quantity limits—for example, a 30-day supply—to reduce costs and encourage proper use.

How do I take advantage of mail-order service?
You'll likely need a new 90-day prescription from your doctor. Mail order can take a few weeks to establish. So it's a good idea to ask your doctor for a 30-day prescription to fill at a retail pharmacy

in the meantime.

We'll Help You Through The Transition

After you enroll, check out things to know **before your benefits start**.

Medicare Basics

Medicare is a federal medical insurance program, which includes Original Medicare. Original Medicare is a low-cost government insurance program that guarantees access to health insurance for Americans age 65 and older and younger people with certain medical disabilities. It pays for many health care expenses, but not all.

How It Works

Medicare covers its share of an approved amount and you pay the rest through deductibles and coinsurance. Original Medicare is made up of two parts:

- **Part A is hospital insurance.** It covers inpatient hospital care, skilled nursing facilities, hospice, lab tests, surgery, and home health care.
- **Part B is medical insurance.** It covers things like clinical research, ambulance services, durable medical equipment, mental health services, limited outpatient prescription drugs, and more.

You are automatically eligible for Medicare Parts A and B when you become Medicare-eligible. If you are receiving Social Security benefits, you may be enrolled in Medicare automatically.

If you have to sign up to get coverage, you can enroll starting three months before the month you turn age 65. The deadline to enroll is three months after the month you turn age 65. (Note: You can wait to enroll in Part B; however, you may have to pay a late enrollment penalty. In general, you can wait to enroll in Medicare Part B without facing a late enrollment penalty until your active employment ends or the date your coverage under your employer's plan ends, whichever occurs first. Consult your Medicare advisor for more details.)

Part D is optional prescription drug coverage. You can enroll in Part D if you want coverage to help pay for your prescription drug costs.

How Medicare Works With Company Coverage

If you are actively employed and enrolled in your employer's health plan, that plan will serve as your primary medical coverage. Should you elect to also enroll in Medicare, Medicare will function as secondary coverage.

In cases where you are eligible for Medicare due to End-Stage Renal Disease (ESRD), your employer sponsored group health plan will be the primary payer for a coordination period of up to 30 months, during which Medicare will act as the secondary payer. After this 30-month period, Medicare will become the primary payer, with the group health plan providing secondary coverage.

It is important to note that once you enroll in any part of Medicare (whether Part A or Part B), you will no longer be eligible to contribute to a Health Savings Account ("HSA"), even if you remain enrolled in an HSA eligible medical plan.

If you are retired and receive coverage through a former employer, Medicare will be your primary medical coverage, and the employer sponsored health plan will serve as secondary coverage.

As you prepare to transition to Medicare, you will want to understand if your dependents under age 65 will be eligible for coverage under your company's health plan.

How Medicare Works With COBRA

If you are eligible for Medicare Parts A and B but you choose to not enroll in Medicare Parts A and B, you may face potentially significant out-of-pocket expenses. COBRA coverage pays secondary to Medicare Parts A and B. Therefore, the plan will pay as if Medicare has already made a payment, even if the Medicare-eligible individual did not actually enroll in Medicare.

If your Medicare benefits (Parts A or B) become effective on or before the day you elect COBRA coverage, you can have COBRA and Medicare coverage. This is true even if your Part A benefits begin before you elect COBRA coverage but you don't sign up for Part B until later.

If you become entitled to Medicare after you've signed up for COBRA coverage, your COBRA coverage may be terminated by your plan as of the day you enroll in Medicare. (But if COBRA covers your spouse and/or dependent children, their coverage may continue.)

To Learn More

Below are resources where you can find additional information and help:

- Visit **Alight Retiree Health Solutions** or call **1.833.791.0780**
- Visit the **Social Security website** or call **1.800.772.1213** (TTY **1.800.325.0778**) between 8:00 a.m. and 7:00 p.m. Monday through Friday
- Review the **Medicare & You** handbook from the Centers for Medicare & Medicaid Services

Accident Insurance

Accidents can slam your wallet too.

Even with medical coverage, your costs related to an accident can be hefty. Depending on the injury, you may be faced with copays, deductibles, hospital charges, transportation fees, and lodging expenses.

Accident insurance pays a benefit in the event you or a family member covered under this plan is in an accident. Accident insurance is not a replacement for medical coverage, but it can help pay deductibles and other gaps in coverage. And, unlike AD&D coverage, accident insurance does not require death or serious injury for you to be eligible for a benefit.

You can learn more about this coverage **here**.

Things To Consider

When deciding whether to enroll in accident insurance, be sure to consider the following:

Cost per Paycheck
The cost of coverage is based on who you cover. You'll be able to see the cost per paycheck when you enroll through the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**.

Your and Your Family's Needs
Does your family lead an active lifestyle? Have you or an eligible family member suffered financial loss resulting from an accident? If you answered "yes" to either question, having accident insurance could give you peace of mind.

Other Coverage
Consider how accident insurance could fit in with other coverage for which you might enroll.

Critical Illness Insurance

When illness strikes, you can strike back. If you experience a serious health condition in the future, critical illness coverage can help lighten the load.

Even with medical insurance, a serious health condition could cost you. Critical illness insurance can provide you with extra cash when you need it most—if you or a family member covered under this plan is treated for a major medical event (such as a heart attack or stroke) or diagnosed with a critical illness (such as cancer or end-stage renal disease). Critical illness insurance is not a replacement for medical coverage, but it can help pay deductibles and other gaps in coverage.

You can learn more about this coverage **here**. Critical illness coverage has limitations and exclusions.

Choose Your Coverage Level

If you decide you want critical illness coverage, you may choose $7,500, $15,000, or $30,000 of coverage.

Things To Consider

When deciding whether to enroll in critical illness insurance, be sure to consider the following:

Cost per Paycheck
The cost of coverage is based on who you cover, age, tobacco status, and the level of coverage you elect. You'll be able to see the cost per paycheck for all your options when you enroll through the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**.

Your and Your Family's Needs
Does a serious health condition run in your family? Would you need financial help to offset the cost of a serious health situation? If you answered "yes" to either question, having critical illness insurance could give you peace of mind.

Hospital Indemnity Insurance

Even with medical insurance, hospital stays can be costly. You may have copays, deductibles, and other incidental hospital charges that add up. That's why you can buy extra insurance through hospital indemnity coverage.

Hospital indemnity insurance pays you a single lump-sum benefit in the event you or a family member covered under this plan is hospitalized. The benefit is based on the type of hospital stay. Hospital indemnity insurance is not a replacement for medical coverage, but it can help pay deductibles and other gaps in coverage.

You can learn more about this coverage **here**.

Things To Consider

When deciding whether to enroll in hospital indemnity insurance, be sure to consider the following:

Cost per Paycheck
The cost of coverage is based on who you cover. You'll be able to see the cost per paycheck when you enroll through the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**.

Your and Your Family's Needs
Does a serious health condition run in your family? Are you or an eligible family member frequently hospitalized? If you answered "yes" to either question, having hospital indemnity insurance could give you peace of mind.

Expert Second Opinion with 2nd.MD

When dealing with illness, injury, or chronic pain, 2nd.MD makes it easy to get a virtual second opinion from nationally-recognized doctors. FTI Consulting is offering employees and family members covered under a BenX medical option the opportunity to connect with board-certified doctors via phone or video.

By calling 2nd.MD, you can get an expert second opinion—within days—when you or a covered family member have questions like:

- Do I have the correct diagnosis?
- Am I on the best treatment plan?
- Am I taking the right medications?
- Is this surgery or procedure the best option for me?

You don't need a referral for an expert second opinion! To get started, simply visit **www.2nd.md/fticonsulting** or call **1.866.887.0712**. Let 2nd.MD do the hard work for you, so you can focus on getting the best care possible.

Paying For Coverage

Expert second opinion with 2nd.MD is a confidential and free service to employees and family members covered under a FTI Consulting medical option.

Things To Consider

Peace of Mind

2nd.MD doctors are highly sought-after doctors—at the top of their fields—and come from leading medical institutions. You'll receive clarity, information, and peace of mind.

It's Risk-Free

If you have medical questions or uncertainty, you can get an expert opinion from the comfort of your home. Plus, it's free to use.

Specialized Expertise

2nd.MD experts are industry leaders across hundreds of specialties and thousands of conditions, including heart disease and stroke; cancer; knee, hip, and ankle surgery; digestive issues; immunological disorders; mental health issues; and more.

Dental Coverage Level

Which Coverage Level Is Best?

You get to choose how much coverage you need and how you want to pay for it. When you choose your coverage level, you get to pick the one with the features you want.

Your coverage level determines how much you pay out of your paycheck (premiums). It also determines how much you pay out of your pocket when you receive care (deductibles, coinsurance, copays). Make sure to take your **total** costs into consideration when choosing a coverage level.

Don't let the names of the coverage levels fool you. One option isn't better than another. The coverage levels are designed to give you choices. It's up to you to find the one that makes sense for your situation.

Dental Coverage Level Options

	BRONZE	SILVER	GOLD	PLATINUM[2]
		Annual Deductible and Plan Limits		
Annual deductible (individual / family)	$100 / $300	$100 / $300	$50 / $150	None
Annual maximum (excludes orthodontia)	$1,000 per person	$1,500 per person	$2,500 per person	None
Orthodontia lifetime maximum[1]	Not covered	$1,500 per child	$2,000 per person	Varies by insurance carrier
		In-Network Benefits		
Preventive care	100% covered, no deductible	100% covered, no deductible	100% covered, no deductible	Varies by insurance carrier; generally covered 100%
Minor restorative care (e.g., root canal treatment, gum disease treatment, and oral surgery)	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	Varies by insurance carrier
Major restorative care (e.g., crowns, implants, dentures)	Not covered	You pay 40% after deductible	You pay 20% after deductible	Varies by insurance carrier

Orthodontia	Not covered	You pay 50%, no deductible; children up to age 19 only	You pay 50%, no deductible; for children and adults	Varies by insurance carrier

[1]If you switch insurance carriers, any orthodontic expenses you've already incurred under your current carrier will count toward your new carrier's orthodontia lifetime maximum.

[2]Not available in some limited areas. Only the coverage levels for which you are eligible will show as options when you enroll.

These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here. In the event that there is a discrepancy between this site and the official plan documents, the official plan documents will control.

These charts are a high-level listing of commonly covered benefits across carriers and coverage levels. They are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits.

For a more detailed look at these and additional coverages, go to the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**. It does account for any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, you will need to call the carrier directly.

Note: For additional comparison, you may find Summaries of Benefits and Coverage on the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**.

Considering Platinum? It may cost less than some of the other options, but you **must** designate a primary care dentist who participates in the insurance carrier's Platinum network (where available by carrier) and get care from your primary care dentist. The network could be considerably smaller, so be sure to check the availability of local in-network dentists before you enroll. If you don't designate a primary care dentist when you enroll, one may be assigned to you. To change your primary care dentist, you will need to contact the insurance carrier directly. If you enroll in a Platinum option and don't use a network dentist, you'll pay for the full cost of services.

Considering Delta Dental? With most carriers, knowing that your dentist is in the network is a simple way to get the best deal when you need care. If you're considering Delta Dental, you need to take it one step further.

- If you choose a Bronze, Silver, or Gold option, there are actually two Delta Dental networks —PPO and Premier. Although the benefits are the same for both, you may have to pay more if your dentist is only a part of the Premier network. You can save more by seeing a Delta Dental dentist who participates in both the PPO and Premier networks, or by using any in-network dentist if you choose another insurance carrier.
- If you choose a Platinum option, the Delta Dental network goes by the name of "DeltaCare." So you need to make sure your dentist is in the DeltaCare network—not just the Delta Dental network. You can also get the same deal by using any in-network dentist if you choose another insurance carrier.

You can check if your provider is part of either network on **yourbenefitsresources.com/fticonsulting/onelogin** or through **Your Carrier Connection**.

Dental Price

Find the right balance between what you pay out of your paycheck and what you pay when you get care.

Just like your medical coverage, your dental coverage costs will depend on a few factors:

The Amount Of Your Contribution From FTI Consulting

All eligible employees will receive a contribution to use toward the cost of coverage.

You'll see the contribution amount from FTI Consulting and your price options for coverage when you **enroll**.

The Coverage Level You Choose

Bronze
The Bronze coverage level generally costs less per paycheck. That's because some services aren't covered and because it has the lowest benefit maximum.

Silver
The Silver coverage level is moderately priced since most services are covered. However, the benefit maximum is lower.

Gold
The Gold coverage level costs more per paycheck since most services are covered. The benefit maximum is also higher.

Platinum
The Platinum coverage level generally costs less. It provides comprehensive coverage for in-network care only.

The Insurance Carrier You Choose

Certain insurance carriers may be able to provide a more competitive price per paycheck.

Your Dependents

You can enroll any combination of you, your eligible spouse/domestic partner, and your children in the option you choose.

Vision Coverage Level

Which Coverage Level Is Best?

You get to choose how much coverage you need and how you want to pay for it. When you choose your coverage level, you get to pick the one with the features you want.

Your coverage level determines how much you pay out of your paycheck (premiums). It also determines how much you pay out of your pocket when you receive care. Make sure to take your **total** costs into consideration when choosing a coverage level.

Don't let the names of the coverage levels fool you. One option isn't better than another. The coverage levels are designed to give you choices. It's up to you to find the one that makes sense for your situation.

Vision Coverage Level Options

	BRONZE	SILVER	GOLD
		In-Network Benefits	
Routine vision exam (once per plan year)	Covered 100%	You pay $10	Covered 100%
Frames (once per plan year)	Discount may apply	$150 allowance[1]	$200 allowance[1]
		Lenses (once per plan year; premium lenses may cost more)	
Single vision	Discount may apply	You pay $20	You pay $10
Bifocal	Discount may apply	You pay $20	You pay $10
Trifocal	Discount may apply	You pay $20	You pay $10
Standard Progressive[2]	Discount may apply	You pay $20	You pay $10
Lenticular	Discount may apply	You pay $20	You pay $10
		Lens Enhancements	

UV treatment	Discount may apply	Varies by carrier	Varies by carrier
Tint (solid and gradient)	Discount may apply	Varies by carrier	Varies by carrier
Standard plastic scratch-resistant coating	Discount may apply	Varies by carrier	Varies by carrier
Standard anti-reflective coating	Discount may apply	Varies by carrier	Varies by carrier
Standard polycarbonate (adults)	Discount may apply	Varies by carrier	Varies by carrier
Standard polycarbonate (children)	Discount may apply	You pay nothing	You pay nothing
Other add-ons	Discount may apply	Discount only	Discount only
Contact Lenses			
Medically necessary	Not covered	You pay $20	You pay $10
Elective	Not covered	$150 allowance[1]	$200 allowance[1]
Fit and evaluation	Discount may apply	You pay $20	You pay $10
Laser Surgery			
Elective	15% off regular price or 5% off promotional price	15% off regular price or 5% off promotional price	15% off regular price or 5% off promotional price

[1]Allowance can be used for frames or elective contact lenses, but not both.

[2]Vision benefits are for standard progressives. Enhanced progressives may cost more and will vary by insurance carrier.

These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here. In the event that there is a discrepancy between this site and the official plan documents, the official plan documents will control.

These charts are a high-level listing of commonly covered benefits across carriers and coverage levels. They are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits.

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Note: For additional comparison, you may find Summaries of Benefits and Coverage on the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**.

Vision Price

Find the right balance between what you pay out of your paycheck and what you pay when you get care.

Just like your medical coverage, your vision coverage costs will depend on a few factors:

The Amount Of Your Contribution From FTI Consulting

All eligible employees will receive a contribution to use toward the cost of coverage. You'll see the contribution amount from FTI Consulting and your price options for coverage when you **enroll**.

The Coverage Level You Choose

The Bronze option will generally be less expensive per paycheck. That's because it covers only exams with some in-network discounts available. The Silver and Gold options will cost more per paycheck and provide coverage for exams as well as frames and lenses.

The Insurance Carrier You Choose

Certain insurance carriers may be able to provide a more competitive price per paycheck.

Your Dependents

You can enroll any combination of you, your eligible spouse/domestic partner, and your children in the option you choose.

Flexible Spending Accounts (FSAs)

FTI Consulting offers two tax-advantaged **FSAs**: the Health Care FSA and Dependent Care FSA. Both FSAs are administered by Alight Smart-Choice Accounts.

Health Care FSA

A Health Care FSA allows you to set aside dollars from your pay on a pre-tax basis to reimburse yourself for qualified medical, dental, and vision expenses.

The Health Care FSA contribution limit is $3,300 for 2026. Once you enroll and set your annual contribution, you cannot change that amount during the year (except in the case of certain qualified life events).

With the Health Care FSA, you can roll over up to $660 from year to year, so it's important that you carefully estimate your anticipated eligible expenses for the coming year.

Wondering what the difference is between a Health Savings Account (HSA) and Health Care FSA? **Find out.**

Dependent Care FSA

A Dependent Care FSA may be used to reimburse yourself for qualified child and dependent care expenses. You may use this account without being enrolled in medical coverage.

The Dependent Care FSA contribution limit is $7,500 (or $3,750 if you are married and filing taxes separately) for 2026. Once you set your annual contribution when you enroll, you cannot change that amount during the year (except in the case of certain qualified life events).

And, with the Dependent Care FSA, you lose any unused money at the end of the year, so it's important that you carefully estimate your anticipated eligible expenses for the coming year.

Things To Consider

When deciding whether to enroll in FSAs, be sure to consider the following:

Tax savings
Do you have moderate to high health care or dependent care expenses? If so, an FSA could help reduce how much you pay in taxes.

Your expected expenses
Carefully estimate your anticipated eligible expenses for the coming year. You should only set aside FSA dollars you know you will be able to use on eligible expenses.

Life Insurance

Protect your loved ones. Choose the amount of life insurance coverage that's right for you and your family.

Life insurance protects your family financially in the event of a death. FTI Consulting automatically provides basic life insurance for you free of charge.* And, if you decide your family needs more protection, you can buy supplemental coverage for yourself, your spouse/domestic partner and your children.

Life insurance is administered by Lincoln Financial Group.

* Federal tax law requires you to pay taxes on the cost of basic life insurance coverage over $50,000. This is called "imputed income" and will be added to your gross taxable income. It will be included on your paychecks and on your Form W-2 each year. The amount of imputed income is based on your age and coverage amount.

Basic Life

You will automatically be enrolled in basic life insurance. The basic life insurance benefit equals 1.5 times your annual eligible earnings rounded to the next highest $1,000, up to a maximum benefit of $300,000. To avoid paying imputed income, you may elect a reduced coverage amount of $50,000. Your payroll contribution is withheld on a pre-tax basis.

Benefit Reduction Schedule: Benefits will reduce to 65% at age 70, 45% at age 75, and 30% at age 80. The reduction will take effect on January 1 of the year following your birthday, unless your birthday is January 1, then the reduction takes effect the same year as your birthday.

Supplemental Life

You may elect to purchase additional supplemental life insurance coverage. Coverage is elected as a specified dollar amount in $10,000 increments up to a maximum of five times your annual eligible earnings or $1.7 million, whichever is less. When you are first eligible for FTI's group benefits, you may elect up to $800,000 of supplemental life insurance without having to provide evidence of insurability (EOI) while the amount elected over $800,000 will require that you submit EOI to the insurance carrier, Lincoln Financial Group. After your initial benefits eligibility, new coverage elections or increases of more than $100,000 to your current coverage election will require that you provide EOI.

The cost of coverage is based on your age and eligible earnings and as these factors change, the cost of coverage changes. Your payroll deduction for the supplemental life insurance is withheld on a post-tax basis.

Benefit Reduction Schedule: Benefits will reduce to 65% at age 70, 45% at age 75, and 30% at age 80. The reduction will take effect on January 1 or the year following or coincident with the applicable birthday.

Spouse Life

You may purchase life insurance on your spouse/domestic partner in increments of $10,000 up to a maximum benefit of $250,000. Evidence of insurability (EOI) is required for amounts of coverage over $50,000. If you opt out of spouse/domestic partner life insurance at the time of initial eligibility and elect coverage at a later date, EOI will be required.

The premium for the coverage is based on your spouse's/domestic partner's age. Your payroll deduction for spouse life insurance is withheld on a post-tax basis.

Child Life

You may purchase life insurance for your child(ren) in increments of $5,000 up to a maximum benefit of $25,000. Unmarried dependent children up to age 26 are eligible for this coverage. Your payroll deduction for child life insurance is withheld on a post-tax basis.

Choose Your Beneficiaries

Your family depends on you for all kinds of things—including your pay. Make sure to choose the people and/or estate that should receive your life insurance benefit if you die. It is important that you make your beneficiary elections on the FTI Benefits Center website.

First, gather the Social Security numbers and birth dates for each beneficiary. Then, when you're enrolling in life insurance through the FTI Benefits Center website, you'll be prompted to designate your beneficiaries.

You can change beneficiaries at any time. If you die and have no beneficiaries on file, the benefit may— or may not—eventually reach the individual(s) you would prefer. The result could be a significant delay in payment during an already challenging time for your loved ones.

Things To Consider

When deciding whether to enroll in supplemental life insurance coverage, be sure to consider the following:

Cost per Paycheck
The cost of supplemental life insurance coverage is based on your and your spouse's/domestic partner's age and level of coverage. You'll be able to see the cost per paycheck for your options when you enroll through the FTI Benefits Center website.

Your Family's Needs
Remember that life insurance is intended to help protect your family financially if a covered family member dies. Would you have enough money to pay funeral expenses? Would you need to replace an income?

Every situation is different, so consider your family situation carefully.

Evidence of Insurability (EOI) requirements
EOI is not required for basic life and child life insurance. In order to buy certain levels of supplemental life insurance coverage, you'll need to prove that you are in good physical health by completing an EOI.

If EOI is required, you will get instructions on how to access the form as you complete your enrollment online. Please fill out the form and submit it promptly. Full coverage won't take effect until the carrier approves your coverage. If you don't submit the EOI form or it doesn't get approved, you'll get the highest level of coverage that doesn't require EOI, if any.

AD&D Insurance

Accidents happen. It's a fact of life. But you can soften the financial impact of an accidental death or injury.

Accidental death and dismemberment (AD&D) benefits protect your family financially in the event of a tragic accident. FTI Consulting automatically provides basic AD&D coverage for you free of charge. And, if you decide your family needs more protection, you can buy supplemental AD&D coverage for yourself, your spouse/domestic partner, and your children.

AD&D is administered by Lincoln Financial Group.

Basic AD&D

You will automatically be enrolled in basic AD&D coverage. The basic AD&D benefit equals 1.5 times your annual eligible earnings rounded to the next highest $1,000, up to a maximum benefit of $300,000.

Supplemental AD&D

You may elect to purchase supplemental AD&D coverage at one to five times your annual eligible earnings up to $1.7 million. Your payroll deduction for the supplemental AD&D coverage is withheld on a pre-tax basis.

Spouse AD&D

You may purchase AD&D coverage on your spouse/domestic partner in increments of $10,000 up to a maximum benefit of $250,000. Your payroll deduction for spouse/domestic partner AD&D coverage is withheld on a post-tax basis.

Child AD&D

You may purchase AD&D coverage for your child(ren) in increments of $5,000 up to a maximum benefit of $25,000. Unmarried dependent children up to age 26 are eligible for this coverage. Your payroll deduction for dependent child AD&D coverage is withheld on a post-tax basis.

Choose Your Beneficiaries

Your family depends on you for all kinds of things—including your pay. Make sure to choose the people and/or estate who receive your AD&D benefit if you die as the result of an accident. It is important that you make your beneficiary elections on the FTI Benefits Center website.

First, gather the Social Security numbers and birth dates for each beneficiary. Then, when you're enrolling in AD&D through the the FTI Benefits Center website, you'll be prompted to designate your beneficiaries.

You can change beneficiaries at any time. But if you die and have no beneficiaries on file, the benefit may—or may not—eventually reach the individual(s) you would prefer. The result could be a significant delay in payment during an already challenging time for your loved ones.

Note: You are the beneficiary if you're seriously injured as the result of an accident. The benefit paid is based on a percentage of your AD&D coverage amount, depending on your type of loss.

Things To Consider

When deciding whether to enroll in supplemental AD&D coverage, be sure to consider the following:

Cost per Paycheck
The cost of supplemental AD&D coverage is based on the level of coverage you elect. You'll be able to see the cost per paycheck for your options when you enroll through the FTI Benefits Center website.

Your AD&D Election(s)
Remember that AD&D coverage is intended to help protect your family financially if you or a covered family member dies or suffers a serious injury resulting from an accident. **Because AD&D coverage pays a benefit only in the event of an accident, it is not a substitute for life insurance.**

Disability

Could you pay your bills if an illness or injury prevented you from working? Disability benefits can help.

Disability benefits are administered by Lincoln Financial Group.

Short-Term Disability (STD)

STD benefits replace a portion of your income if you're unable to work due to a pregnancy, illness, or non-work-related injury. FTI Consulting automatically provides STD coverage for you free of charge.

The STD benefit begins on the eighth calendar day for an accident, illness or maternity case for which you are unable to work. Under the plan, the first seven days of a disability is considered the elimination or waiting period. During this waiting period, FTI Consulting will pay employees at 100% of their regular pay.

STD benefits are paid up to a maximum of 180 days. During this period of disability, benefits will be adjusted to take into account any other sources of income and state mandated benefits—making sure that your disability pay would not exceed 66.67% of your calculated benefit, as defined herein.

The benefit will be 66.67% of your annual eligible earnings as of the date you become unable to work. The benefit calculated on $500,000 or less in earnings will not be subject to taxes because the premiums are subject to tax. The benefit calculated on more than $500,000 will be subject to tax.

Examples of Salary Continuation—Accident, Illness, and Maternity

- Day 1 – 7: 100% of regular earnings paid by FTI Consulting
- Day 8 – 180: 66.67% of weekly eligible earnings

Long-Term Disability (LTD)

FTI Consulting automatically provides basic LTD coverage for you free of charge. LTD benefits pick up where your STD benefits end. The policy provides disability income protection in the event of an illness or injury that lasts in excess of 180 days. The benefit is 60% of monthly eligible earnings up to a maximum monthly benefit of $15,000. The maximum benefit is equivalent to 60% of annual eligible earnings of $300,000, and it will be tax-free to you when paid because the premiums are subject to tax.

Long-Term Disability Buy-Up

If you have annual eligible earnings in excess of $300,000, you have the option to purchase additional coverage that would provide a 60% benefit on up to $500,000 of eligible annual earnings. That means you would receive an additional monthly benefit of up to $10,000 for a total

maximum benefit of $25,000. This buy-up coverage will also be tax-free because the premiums are paid on an after-tax basis, and you are only responsible for paying the premiums on the benefit in excess of the basic LTD coverage.

Additional Plan Features And Limitations

In the event a disability lasts beyond 12 months and is significant enough to limit the ability of the disabled employee from performing two or more Activities of Daily Living (ADLs), additional benefits are available. Additional information is available in the plan document.

The length of claim is determined by Lincoln Financial Group and is based on documentation provided by your physician. LTD benefits typically continue to the age of 62. If you are disabled at age 62 or older, the table below reflects the duration of benefits based on your age at the time of your disability.

Maximum LTD Benefit Duration	
Age on Date Disability Starts	Maximum Benefit Duration
Before age 62	Greater of 42 months or to age 65
62	42 Months
63	36 Months
64	30 Months
65	24 Months
66	21 Months
67	18 Months
68	15 Months
69 and over	12 Months

Things To Consider

When deciding whether to enroll in LTD disability buy-up coverage, be sure to consider the following:

Cost per Paycheck
The cost of disability coverage is based on the level of coverage you elect. You'll be able to see the cost per paycheck when you enroll through the FTI Benefits Center website.

Other Income Sources
If you were unable to work, would other sources of income be available to you, such as sick pay, salary continuance, a short-term state disability plan, or Social Security? If so, consider whether you would have enough money to pay your ongoing expenses for a period of time.

Taxes
Disability benefits may be taxable as ordinary income. That means federal and state income taxes will be deducted from disability benefit checks. When choosing a disability coverage level, be aware that taxes may affect the dollar amount of your benefit.

Legal Services

You don't want to spend a fortune to get legal advice when you need it. Legal Services coverage offers a network of attorneys who can help with creating or updating a will, real estate matters, tax audits, document preparation, and more.

If you use a network attorney, you don't pay any fees, deductibles, or copays. For a complete list of network attorneys and covered services, go to **https://www.legaleaseplan.com/fticonsulting**.

Legal Services is a voluntary benefit administered by LegalEASE. The plan covers employees and eligible family members.

Things To Consider

When deciding whether to enroll in Legal Services, be sure to consider the following:

Cost per Paycheck
If you expect to need Legal Services, the cost of coverage could be less than if you paid an in-network attorney directly. You'll be able to see the cost per paycheck when you enroll through the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**.

Your Personal Situation
Consider your expected legal needs and access to network attorneys. Do you plan to purchase, sell, or refinance a home? Do you need help preparing a will or trust? If you answered "yes" to either question, having Legal Services coverage could give you peace of mind.

Identity Theft Protection

Victims of identity theft spend countless hours trying to sort out the damage.

Identity theft protection could help you catch fraud in its early stages through 24/7 monitoring of your personal and financial information. It can also help you act quickly to limit damage if your personal or financial information is stolen.

For more information, you can visit **https://www.lifelockbusinesssolutions.com**.

Identity theft protection is a voluntary benefit administered by NortonLifeLock. The plan covers all eligible family members.

Things To Consider

When deciding whether to enroll in identity theft protection, be sure to consider the following:

Cost per Paycheck
You'll be able to see the cost per paycheck when you enroll.

Your Risk Factors
While everyone has risk, some people are at greater risk than others. Have you used credit cards on unsecure websites? Do you make online purchases regularly? If you answered "yes" to either question, having identity theft protection could give you peace of mind.

Pet Insurance

Pet insurance allows you to focus on your pet's health—not how to pay for it.

Pet insurance can help pay veterinary expenses for a sick or injured dog or cat. It covers a wide range of services with no annual or lifetime limits. There is not a network of providers—you can use any licensed veterinarian. Go **here** for a complete list of covered services.

You can add or drop coverage at any time during the year. You can learn more and enroll through the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**.

Paying For Coverage

You'll pay your premiums by credit or debit card.

Things To Consider

When deciding whether to enroll in pet insurance, be sure to consider the following:

Cost
Your cost of coverage is based on the type of pet, breed, and age. Coverage is provided by pet. So if you have more than one, you can get a personalized quote for each.

Your Pet's Needs
Does your pet need regular veterinary care? Are you paying a lot of money out of your pocket for veterinary care? If you answered "yes" to either question, having pet insurance could give you peace of mind.

Flexibility
Since you can add or drop coverage at any time, it's easy to make a change if the need arises.

How to Enroll

Log on to the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin** or the Alight Mobile app (available through the **Apple App Store** or **Google Play**) to enroll in your benefits for 2026.

Following your enrollment, you may still need to take action. If you do, the required follow-ups will appear on a confirmation page.

There are also things you should do to set yourself up for success **after you enroll**.

Questions?

Once logged on to the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**, look for the "Need Help?" icon to ask your virtual assistant any questions you may have. It can also connect you with a web chat representative and other helpful resources. For additional support, you can schedule an appointment with a customer service representative through the FTI Benefits Center website. You can also call the FTI Benefits Center at **1.844.249.8586 (or 1.312.843.5256 for international callers)** from 8:00 a.m. to 8:00 p.m. ET, Monday through Friday.

Actions After You Enroll

Now that you've enrolled, it's time to focus on the road ahead. And there are things you need to do **now** to use your benefits successfully when they take effect.

Here's your to-do list:

Know How Your Prescription Drug Plan Works

Your prescription drug coverage is provided through your insurance carrier, who sets the rules for how medications are covered. Visit your carrier's website for information about your medications. You can also check out the **Prescription Drug Transition Worksheet** (PDF) for tips and questions you may need to ask your carrier.

Check the Formulary

A **formulary** is a list of generic and brand name drugs that are approved by the Food and Drug Administration (FDA) and are covered under your prescription drug plan. **Check with your carrier** to make sure your drug is listed on the formulary **before** you fill it. If it isn't, you'll pay more.

Go Generic

Generic drugs meet the same standards as brand name drugs, but they **typically** cost less. And, because brand name drugs can be expensive, some carriers don't cover them **at all** if a generic is available. Ask your doctor if a generic drug is available for you.

Mail-Order Setup

Mail-order service can save you a trip to the pharmacy and may reduce your costs. To set up mail order with a new medical insurance carrier, you'll likely need a new 90-day prescription from your doctor. Because mail-order can take a few weeks to establish, it's a good idea to ask your doctor for a 30-day prescription to fill at a retail pharmacy in the meantime.

Track your to-dos and get organized—print the **Prescription Drug Transition Worksheet** (PDF).

"Transition Of Care" Setup

Are you or a covered family member pregnant? Will you or your covered family member continue needing treatment for an ongoing medical condition?

If you will have a new medical insurance carrier and you answered "yes" to either question, you may be able to temporarily continue that care with your current provider once your **new** medical coverage begins. This is true even if your provider isn't in the new insurance carrier's network.

If you think this applies to you, **call customer service** at your **new** medical insurance carrier as soon as possible to ask for help with "transition of care."

Give your new insurance carrier information about your treatment and the providers you use today.

Will you have a new dental plan? Will you or your child(ren) continue receiving ongoing orthodontic treatment? **Call customer service** at your **new** dental insurance carrier as soon as possible to ask for help with "transition of care."

Track your to-dos and get organized—print the **Transition of Care Worksheet** (PDF).

Avoid Unexpected Out-Of-Network Costs

It's very important to know whether your doctor participates in your medical insurance carrier's network.

You Could Pay a Lot More for Out-of-Network Care

Insurance carrier member sites and apps have resources that can help you look up the cost of care. But your medical insurance carrier could pay a much lower benefit if you see an out-of-network doctor—leaving you to pay the rest.

For instance, you will pay more through a higher out-of-network deductible and higher coinsurance. You'll also have to pay the entire amount of the out-of-network provider's charge that exceeds the maximum allowed amount, even after you've reached your annual out-of-network out-of-pocket maximum.

Each medical insurance carrier can determine its maximum allowed amounts for out-of-network providers. For example, among other ways, carriers may use what's considered "reasonable and customary" and/or a Medicare-based calculation to determine the maximum allowed amount.

Example
For example, let's say you will have an out-of-network surgery that costs $5,000 and you will pay 45% coinsurance. The maximum allowed amounts could be different across carriers:

- If one carrier has a maximum allowed amount of $2,000, you would owe 45% of $2,000 and 100% of the remaining $3,000, for a total of $3,900.
- If a second carrier has a maximum allowed amount of $3,000, you would owe 45% of $3,000 and 100% of the remaining $2,000, for a total of $3,350.

Take These Steps to Protect Yourself

If you *didn't* check your doctor's status before you enrolled or you want to look up a different doctor, do it *now*—before making an appointment with that doctor.

You can check the provider directory through the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin** or your **insurance carrier's website**.

Important! Do not rely on your provider's office to know the carriers' network(s). If you have any uncertainty (for instance, covering out-of-area dependents) or you need the network name, call the insurance carrier.

Even if you're keeping the same insurance carrier, the provider network could be different. **Always** check the provider directories on the carrier preview sites before making a decision.

If your doctor is out-of-network and you still want to see them, check the cost with your doctor *before* you get care. Then ask your doctor to confirm the portion that will be covered by your medical insurance carrier and the portion for which you'll be responsible. That way you'll be prepared for any potentially significant costs.

When To Expect New Cards

You'll get a printed or digital ID card when you enroll for the first time or change insurance carriers or coverage levels. You'll use your ID card for medical and prescription drug needs. (**Note:** You can access digital ID cards via the carrier's member website or app.)

Note: Many dental insurance carriers also issue ID cards. If you receive one, simply present it when you get dental care during the new plan year.

For questions about ID cards, **contact the insurance carrier**. If you need an ID card immediately, go to your insurance carrier's website, register online, and print a temporary ID card.

Contributing To An HSA?

If you enrolled in the Bronze Plus or Silver coverage levels, you had the option to elect to contribute to an HSA.

If you decided to put money in an HSA for the first time, you'll receive a welcome letter and HSA debit card in the mail. If you decided to put money in your HSA and you've previously contributed to the HSA, you'll continue to use your existing debit card. New money added to your account will be accessible through your current debit card.

How to Get Care

When you get care, it helps to know what you can expect. Remember, insurance carrier member sites and apps have resources that can help you look up the cost of care before you go.

Getting Care At The Doctor's Office

Present your medical ID card at your doctor's office. If you're enrolled in the Bronze Plus or Silver coverage levels, you can wait to pay until your insurance carrier processes the claim and you get your doctor's bill.

When it's time to pay, you can **pay with your HSA**, FSA, or pay another way—it's your choice!

Filling Prescription Drugs At A Retail Pharmacy

Present your medical ID card each time you drop off a prescription. If payment is due, you pay out of pocket (or you can **pay with your HSA** or FSA if you have one).

Know When You'll Owe

If your doctor bills services as preventive care or your medication is listed as preventive on the formulary, you'll owe nothing. For other types of covered services or non-preventive prescription drugs, you could owe a deductible, copay, and/or coinsurance.

Remember: You'll Pay Less With In-Network Providers

You can check the provider directory on the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin** or refer to your **insurance carrier's website**.

If a doctor is out-of-network and you still want to see them, check the cost with the doctor before you get care.

Then, ask the doctor to confirm the portion that will be covered by your medical insurance carrier and the portion for which you will be responsible.

That way, you'll be prepared for potentially significant costs.

Remember: Not all options cover out-of-network care.

Paying for Care

When you receive medical care, you choose how to pay your share of the cost. Follow these easy steps when it's time to get care:

Step 1: Meet With Your Provider

Don't forget, you'll probably pay **a lot** less when you see in-network providers. You can check the provider directory on the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin** or refer to your **insurance carrier's website**.

Remember: Not all options cover out-of-network care.

Step 2: Present Your Medical ID Card

When you visit your doctor, hospital, or other health care provider, remember to show them your ID card so they know how to bill for the services they are providing you.

Step 3: Review The Explanation Of Benefits (EOB)

An EOB is **not** a bill. It's simply a statement from your insurance carrier that shows when you got care and how much it cost.

It will show your provider's charges, the negotiated amount your insurance carrier agreed to pay, how much is covered (if any), and your payment responsibility.

Remember, if you haven't met your deductible, you could owe the entire negotiated amount. Keep the EOB for your records because you'll need it for the next step.

Step 4: Review Your Provider's Bill

A provider's bill typically arrives in your mailbox after the EOB arrives. The amount you owe on your provider's bill should match what's on the EOB.

Step 5: Pay Your Provider

You can pay your provider out of pocket or you can **pay with your HSA** or FSA for eligible health care expenses.

Paying With Your HSA

You can open an HSA if you enrolled in a Bronze Plus or Silver coverage level. When it's time for you to pay for care or prescription drugs, your HSA gives you options:

Use Your HSA Debit Card

Just use it when you're ready to pay for qualified medical expenses. The funds will be taken directly from your account.

Make sure you only use the card for eligible expenses, and that you have enough money in your HSA to cover it.

Log on to Bank of America at **https://myhealth.bankofamerica.com** to check your balance beforehand.

Pay Out Of Pocket

If you prefer, you can pay for your expenses up front and pay yourself back through your HSA later. You'll log on to Bank of America at **https://myhealth.bankofamerica.com** to transfer money from your HSA to your regular bank account.

Eligible Expenses

You can find a complete list of eligible expenses at **https://www.irs.gov/publications/p502**.

Don't forget! If you use money from your HSA to pay for nonqualified expenses, you'll pay taxes on that money. You'll also pay an additional 20% penalty tax if you're under age 65. This applies to expenses such as child care, cosmetic surgery, health club fees, teeth whitening products, and vitamins.

Keep Your Receipts!

Always remember to save your receipts when you make payments from your HSA, in case you need to provide proof of your eligible expenses to the IRS.

Transparency in Coverage

Your employer is subject to the Affordable Care Act's requirements to make certain information available to the public. These links lead to the machine-readable files that are published in response to the federal Transparency in Coverage Rule and include negotiated service rates and out-of-network allowed amounts between health plans and health care providers. The machine-readable files are formatted to allow researchers, regulators, and application developers to more easily access and analyze data.

- **Aetna:** https://health1.aetna.com/app/public/#/one/insurerCode=AETNACVS_I&brandCode=ALICFI/machine-readable-transparency-in-coverage
- **CareFirst:** https://individual.carefirst.com/individuals-families/mandates-policies/machine-readable-file.page
- **Cigna:** https://www.cigna.com/legal/compliance/machine-readable-files
- **Dean/Prevea360:**
    - https://www.Deancare.com/transparencyincoverage
    - https://www.Prevea360.com/transparencyincoverage
- **HealthNet:** https://www.centene.com/price-transparency-files.html
- **Kaiser:** https://healthy.kaiserpermanente.org/front-door/machine-readable
- **Med Mutual of OH:** https://medmutual.healthsparq.com/healthsparq/public/#/one/insurerCode=MMO_I&brandCode=MMO&productCode=MRF/machine-readable-transparency-in-coverage
- **Priority Health:** www.priorityhealth.com/landing/transparency
- **United Healthcare:** https://transparency-in-coverage.uhc.com
- **UPMC:** https://www.upmchealthplan.com/transparency-in-coverage/mrf/

Your Carrier Connection

Check out your health care insurance carrier choices—and see all the unique features and services they have to offer. Discover what each provides, see the doctors included in their network, and then decide for yourself.

Medical

Carrier Name: **Aetna**

Areas We Serve: Offered in all states except AK, ID, MT, WY, MO, and SD. Availability in some states may be limited.

Before you're a member (preview site): https://www.aetna.com/microsites/aon/fibroad/index.html

Once you're a member (website): https://www.aetna.com

Customer Service Hours: Monday - Friday:
8:00 am - 6:00 pm
local time

Phone Number: 1.855.496.6289

Learn More

Carrier Name: **CareFirst**

Areas We Serve: Available nationally

Before you're a member (preview site): https://www.carefirst.com/aon/

Once you're a member (website): https://www.carefirst.com/myaccount/

Customer Service Hours: Monday - Friday:
8:00 am - 8:00 pm EST

Phone Number: 1.844.439.6482

Learn More

Carrier Name: **Cigna**

Areas We Serve: Available nationally with the exception of MN and ND.

Before you're a member (preview site): https://connections.cigna.com/carrierbenefits-fi2026/

Once you're a member (website): https://my.cigna.com

Customer Service Hours: Cigna Support
is available 24/7/365

Phone Number: 1.855.694.9638 , For Cigna company names and product disclosures, visit Cigna.com/product-disclosure.

Learn More

Carrier Name: **Dean/Prevea360**

Areas We Serve: South Central and Northeastern Wisconsin

Before you're a member (preview site): http://aon.deanhealthplan.com/

Once you're a member (website): http://aon.deanhealthplan.com/

Customer Service Hours:
Monday - Thurday:
7:30 am - 5:00 pm CST

Friday:
8:00 am - 4:30 pm CST

Phone Number: 1.877.357.3164

Learn More

Carrier Name: **Health Net**

Areas We Serve: Available in CA

Before you're a member (preview site): https://www.healthnet.com/myaon

Once you're a member (website): https://www.healthnet.com/myaon

Customer Service Hours: Monday - Friday:
8:00 am - 6:00 pm PST

Phone Number: 1.888.926.1692

Learn More

Carrier Name: **Kaiser Permanente**

Areas We Serve: Generally available in WA

Before you're a member (preview site): https://kp.org/aon

Once you're a member (website): https://www.kp.org

Customer Service Hours: Monday - Friday:
8:00 am - 5:00 pm PST

Phone Number: 1.855.407.0900

Learn More

Carrier Name: **Kaiser Permanente**

Areas We Serve: Generally available in CA, CO, DC, GA, MD, VA, OR, and southwest WA

Before you're a member (preview site): http://kp.org/aon

Once you're a member (website): https://www.kp.org

Customer Service Hours:
CA: 24/7
except major holidays

CO: Monday - Friday:
8:00 am - 6:00 pm MST

GA: Monday - Friday:
7:00 am - 7:00 pm EST

DC, MD, VA:

Monday - Frday:
7:30 am - 9:00 pm EST

OR and WA (Vancouver/Longview area):
Monday - Friday:
8:00 am - 6:00 pm PST

Phone Number:

1.877.580.6125 , CA Post-enrollment:
1.800.464.4000
(Gold II & Platinum);
1.800.788.0710
(All other metallics)

CO Post-enrollment:
1.800.632.9700 (Platinum);
1.855.364.3185
(All other metallics)

GA Post-enrollment:
1.888.865.5813 (Platinum);
1.855.364.3185
(All other metallics)

DC, MD, VA Post-enrollment:
1.800.777.7902 (Platinum);
1.888.225.7202
(All other metallics)

Southwest WA
Post-enrollment:
1.800.813.2000 (Platinum);
1.866.616.0047
(All other metallics)

Pre-enrollment Phone Number: 1.877.580.6125

Learn More

Carrier Name: **Medical Mutual**

Areas We Serve: Generally available in OH

Before you're a member (preview site): http://www.medmutual.com/aon

Once you're a member (website): https://member.medmutual.com

Customer Service Hours:

Monday - Thursday:
7:30 am - 7:30 pm EST

Friday:
7:30 am - 6:00 pm EST

Saturday:
9:00 a.m. - 1:00 p.m. EST

Phone Number: 1.800.541.2770

Pre-enrollment Phone Number: 1.800.677.8028

Learn More

Carrier Name: **Priority Health**

Areas We Serve: Available in the lower peninsula of MI

Before you're a member (preview site): https://www.priorityhealth.com/aon

Once you're a member (website): https://member.priorityhealth.com/

Customer Service Hours:
Monday - Thursday:
7:30 am - 7:00 pm EST

Friday:
9:00 am - 5:00 pm EST

Saturday:
8:30 am - noon EST

Phone Number: 1.833.207.3211

Learn More

Carrier Name: **UnitedHealthcare**

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.whyuhc.com/aon11

Once you're a member (website): http://myuhc.com

Customer Service Hours:
Monday - Friday:
8:00 am - 8:00 pm
local time zone

Phone Number: 1.888.297.0878

Learn More

Carrier Name: **UPMC Health Plan**

Areas We Serve: Generally available in PA

Before you're a member (preview site): https://www.upmchealthplan.com/aon/

Once you're a member (website): https://www.upmchealthplan.com/members/

Customer Service Hours:
Monday - Friday:
8:00 am - 6:00 pm EST

Phone Number: 1.844.252.0690

Learn More

Dental

Carrier Name: **Aetna**

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.aetna.com/microsites/aon/fibroad/index.html

Once you're a member (website): https://www.aetna.com

Customer Service Hours:
Monday - Friday:
8:00 am - 6:00 pm EST

Phone Number: 1.855.496.6289

Learn More

Carrier Name: Cigna

Areas We Serve: Available nationally with the exception of MN and ND.

Before you're a member (preview site): https://connections.cigna.com/carrierbenefits-fi2026/

Once you're a member (website): https://my.cigna.com

Customer Service Hours: Cigna Support
is available 24/7/365

Phone Number: 1.855.694.9638

Learn More

Carrier Name: Delta Dental (Bronze, Silver, and Gold)

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.deltadental.com/us/en/aon/california.html

Once you're a member (website): http://www.deltadentalins.com

Customer Service Hours: Monday - Friday:
8:00 am - 8:00 pm EST

Phone Number: 1.800.471.7614

Pre-enrollment Phone Number: 1.800.503.4162

Learn More

Carrier Name: Delta Dental (Platinum)

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.deltadental.com/us/en/aon/california.html

Once you're a member (website): http://www.deltadentalins.com

Customer Service Hours: Monday - Friday:
8:00 am - 9:00 pm EST

Phone Number: 1.800.471.8073

Pre-enrollment Phone Number: 1.800.546.9751

Learn More

Carrier Name: MetLife

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.metlife.com/aon-benefit-experience

Once you're a member (website): https://www.metlife.com/mybenefits

Customer Service Hours: Monday - Friday:
8:00 am - 11:00 pm EST

Phone Number: 1.888.309.5526

Learn More

Carrier Name: **UnitedHealthcare**

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.whyuhc.com/aon11

Once you're a member (website): https://www.myuhc.com

Customer Service Hours: Monday - Friday:
8:00 am - 8:00 pm
local time zone

Phone Number: 1.888.571.5218

Learn More

Vision

Carrier Name: **EyeMed**

Areas We Serve: Available Nationally

Before you're a member (preview site): https://eyemed.com/en-us/benx-aon

Once you're a member (website): https://member.eyemedvisioncare.com/member/en

Customer Service Hours: Monday - Friday:
7:30 am - 11:00 pm EST

Saturday:
8:00 am - 11:00 pm EST

Phone Number: 1.844.739.9837

Learn More

Carrier Name: **MetLife**

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.metlife.com/aon-benefit-experience

Once you're a member (website): https://www.metlife.com/mybenefits

Customer Service Hours: Monday - Saturday
9:00 am - 8:00 pm EST

Phone Number: 1.888.309.5526

Learn More

Carrier Name: **UnitedHealthcare**

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.whyuhc.com/aon11

Once you're a member (website): https://www.myuhcvision.com

Customer Service Hours: Monday - Friday:
8:00 am - 8:00 pm

local time zone

Phone Number: 1.888.571.5218

Learn More

Carrier Name: **VSP Vision Care**

Areas We Serve: Available Nationally

Before you're a member (preview site): https://www.vsp.com/aon

Once you're a member (website): https://www.vsp.com/login

Customer Service Hours:
Monday - Saturday:
6:00 am - 5:00 pm PT

Sunday: Closed
(IVR available 24/7)

Phone Number: 1.877.478.7559

Learn More

Contacts

Once logged on to the FTI Benefits Center website at **yourbenefitsresources.com/fticonsulting/onelogin**, look for the “Need Help?” icon to ask your virtual assistant any questions you may have. It can also connect you with a web chat representative and other helpful resources. For additional support, you can schedule an appointment with a customer service representative through the FTI Benefits Center website. You can also call the FTI Benefits Center at **1.844.249.8586 (or 1.312.843.5256 for international callers)** from 8:00 a.m. to 8:00 p.m. ET, Monday through Friday.

Health Pros are also available to assist with tough issues like claims and billing disputes.

Questions About Coverage?
Start by contacting the **insurance carrier** directly. They know their coverage rules best.

If you enrolled in a Bronze Plus or Silver medical coverage level, check out the **HSA User's Guide** (PDF) for additional contacts during the year.

Contact a Health Pro

Medical bills can be confusing. That's why FTI Consulting offers expert support to help you understand and resolve medical claims or billing issues. Your Health Pro can review your health care bills to ensure you are charged correctly according to your plan benefits. If there is an error, they will partner with your care provider and health plan on your behalf.

If you aren't satisfied with the resolution, you can file an appeal through your **insurance carrier**, who will be able to direct you through that process. FTI Consulting doesn't have any influence on the outcome. The insurance carrier—not FTI Consulting—is responsible for the cost of claims.

Not sure where to start? Once your coverage has begun, contact your **insurance carrier**. Your insurance carrier is most knowledgeable about coverage rules and has the final decision on all claims and billing questions.

Need Help? Your Health Pro Is Waiting.

Reach out to your Health Pro and they will guide you through the required steps and important deadlines. Your Health Pro can also manage the back-and-forth between your health insurance and doctor, as needed.

Your Health Pro can help:

- Interpret explanation of benefits (EOB) statements.
- Identify and correct claims or billing errors.
- Navigate the health plan appeals process.
- Manage correspondence with your health plan or providers.

If you've contacted your carrier and were unable to resolve your issue, email or call your Health Pro for help.

Email: **AlightHealthPro@alight.com**

Call: **1.866.300.6530**

Get Answers

Have a question? We've got you covered.

Start with the **Frequently Asked Questions** (PDF).

Wondering what something means? Check out the **Glossary**.

Just want to talk to a real person? Here's who to **contact**.

Glossary

Wondering what a term means? Find it here.

Brand Name
A more expensive prescription drug for which there is an active patent. (A patent is a time-sensitive right to market a drug under a certain name.)

Coinsurance
The percentage of costs you pay for eligible expenses after you meet the deductible.

Copay
A flat-dollar amount you pay for certain covered services.

Coverage Level
A benefit level that determines how services are covered.

Deductible
What you pay out of your own pocket before your insurance begins to pay a share of your costs. **How the deductible works** depends on your coverage level. Out-of-network charges do **not** count toward your in-network annual deductible. They only count toward your out-of-network deductible.

Explanation of Benefits (EOB)
An EOB shows the claim filed by your health care professional, what was paid, and what your portion of the payment was or will be. Your insurance carrier provides the EOB. It's not a bill.

Formulary
A list of generic and brand name drugs that are approved by the Food and Drug Administration (FDA) and are covered under your prescription drug plan. You should make sure your medication is on the formulary of the medical insurance carrier you choose.

Generic
Medications that have been approved by the FDA as safe and effective. These medications contain the same active ingredients in the same amounts as brand name products. Generics may be different in color, shape, or size from their brand name counterparts. Your physician may substitute a generic for a brand name drug to save you money.

Health Savings Account (HSA)
A special bank account that allows you to set aside tax-free money to pay for qualified health care expenses. These include your medical, dental, and vision copays, deductibles, and coinsurance.

HMO
Health Maintenance Organization (HMO) options offer care through a network of doctors and hospitals. All of your care generally must be provided through the HMO network and coordinated through the HMO primary care physician (PCP) you select when you enroll. Except in emergencies, your care is usually covered only if it's coordinated by your PCP. There's no coverage for out-of-network care.

Network
A group of health care providers that offer services to participants in a health plan at a negotiated, discounted cost. You'll save money if you use doctors inside your carrier's network.

Out-of-Pocket Maximum
The most you have to pay for covered medical services in a year. Generally, it includes any applicable deductible, copayments, and/or coinsurance. **How the out-of-pocket maximum works**

depends on your coverage level. Out-of-network charges do **not** count toward your in-network annual out-of-pocket maximum. They only count toward your out-of-network out-of-pocket maximum.

Payroll Contribution
The amount deducted from your paycheck on a pre-tax basis to cover your share of health care benefit costs.

Pharmacy Benefit Manager
The insurance carrier or third-party administrator who manages your retail and mail-order prescription drug benefit.

PPO
A Preferred Provider Organization, or PPO, is a type of medical plan that uses a network of physicians, hospitals, and other health care providers that have agreed to provide care at negotiated prices. You can also go to out-of-network providers, but you'll pay more.

Preventive Care
Annual physicals, wellness screenings, immunizations, well-woman exams, well-baby exams, and more. In-network preventive care is 100% covered without having to pay your deductible.

Reasonable and Customary
The normal charge made by a licensed practitioner in a specific area for a specific service. It doesn't exceed the normal charge made by most providers in the area where the service is provided.

Traditional Deductible
Once a covered family member meets the individual deductible, your insurance will begin paying benefits for that family member. Expenses for all other family members will continue to count toward their individual deductible *and* the family deductible. Once any individual family member or combination of family members meet the family deductible, the plan will begin paying coinsurance for all covered members.

Traditional Out-of-Pocket Maximum
Once a covered family member meets the individual out-of-pocket maximum, your insurance will pay the full cost of covered charges for that family member. Expenses for all other family members will continue to count toward their individual out-of-pocket maximum *and* the family out-of-pocket maximum. Once any individual family member or combination of family members meet the family out-of-pocket maximum, the plan will begin paying the full cost of covered charges.

True Family Deductible
The entire family deductible must be met before your insurance will pay benefits for any covered family member.

True Family Out-of-Pocket Maximum
The entire family out-of-pocket maximum must be met before your insurance will pay the full cost of covered charges for any covered family member.

Newly Eligible for Benefits?

Welcome!

Being new to the company, you have a lot on your plate. Enrolling in FTI Consulting benefits is one of those really important “to dos”—and shouldn’t take all that long.

For your 2026 benefits, you can start here:

- **Quick Guide**
- **Enrollment Checklist**
- **Compare Costs** (use the access code provided in recent communications)
- **Medical**
- **Dental**
- **Vision**

Need To Enroll For 2025 *And* 2026 Benefits?

If you’re enrolling in benefits for the rest of 2025 and all of 2026, you should know what to expect for both years. While most things don’t change from year to year, some things could be different.

For your 2025 benefits, you can start here:

- **2025 Benefits Guide (PDF)**
- **Compare Costs** (use the access code provided in recent communications)
- **What's Changing (PDF)** (see what’s different from 2025 to 2026)

Make It Yours

Once you’ve done your homework, if you want coverage through FTI Consulting, you must enroll by your deadline. Otherwise, you won’t have medical and prescription drug, dental, or vision coverage through FTI Consulting for you and your family.

Enroll now

Questions?

Check out the **Frequently Asked Questions** (PDF) for more details.

Helpful Documents

You can learn more through the PDFs below.

Have a Health Savings Account (HSA)?

- **Bank of America HSA Information**

Learn More

- **Alight Mobile App Instructions**

COBRA Coverage Options

If you leave the company or lose coverage due to a status change, your COBRA enrollment notice has details regarding your options.

If you choose not to enroll by your COBRA enrollment deadline, you will not be able to enroll in COBRA coverage in the future. Also, once enrolled, you can make changes to your elections only during enrollment or following a qualified change in status.

You will receive additional information—including prices—once you lose access to health benefits through the company.

Your COBRA Coverage Options

You can start by reviewing your **medical**, **dental**, and **vision** coverage level options.

You'll also want to review your **insurance carrier** options.

How To Enroll

To enroll in COBRA coverage when eligible, follow the instructions on the COBRA enrollment notice mailed to you and enroll at **yourbenefitsresources.com/fticonsulting/onelogin**.